

MEDICAID CUSTOMER SERVICE SURVEY-2004

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

OFFICE OF APPLIED RESEARCH

SFN 53323 (9-2004)

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This survey asks for information about your experiences with North Dakota's Medicaid Program. Your answers to these questions will be helpful in finding out how we can make our Medicaid Program the best possible program.

The "you" in the questions refers to the person this survey was addressed. If "you" are unable to complete the survey, a parent, guardian, spouse, or other close friend/relative may assist. If "you" are no longer enrolled in North Dakota Medicaid at this time, please complete the survey based on the time "you" were enrolled in North Dakota Medicaid.

PLEASE COMPLETE THE FOLLOWING QUESTIONS BASED ON YOUR EXPERIENCES WITH MEDICAID DURING THE PAST 12 MONTHS. When asked, please write out additional information. There are no right or wrong answers. Give the best answers you can. We do not need to know who completed the survey. Please answer the questions and return the survey in the enclosed-paid envelope. Your opinions are important to us. Thank you for taking time to answer.

Shade Ovals Like This -- ● Not Like This -- ☒ ☑

Please use a black or blue pen to complete the survey.

1. How easy was it to apply for Medicaid?

- ☐ 1. Very easy ☐ 2. Somewhat easy ☐ 3. Somewhat difficult ☐ 4. Very difficult

2. How useful was the help you received from your county eligibility worker in completing the Medicaid application?

- ☐ 1. Very useful ☐ 2. Somewhat useful ☐ 3. Not very useful ☐ 4. Not useful at all

3. How satisfied are you with the way you were treated by the county social service agency staff?

- ☐ 1. Very satisfied ☐ 2. Somewhat satisfied ☐ 3. Somewhat dissatisfied ☐ 4. Very dissatisfied

4. Do you feel you have a good understanding of North Dakota Medicaid benefits and services?

- ☐ 1. Yes ☐ 2. No: **What additional information do you need? (Mark all that apply.)**

- ☐ 1. Information about what benefits and services are and are not paid.
☐ 2. Information on how the recipient liability is determined.
☐ 3. Information made available when there are changes in services.
☐ 4. Information on which dentists accept Medicaid payments.
☐ 5. Information on how to understand the medical bills I receive.
☐ 6. Information on who to call if I have questions about Medicaid.
☐ 7. Information on the relationship between Medicaid and Medicare.
☐ 8. Information on the relationship between Medicaid and other insurance.
☐ 9. Other information needed (Please describe):

5. Do you have one person you think of as your personal doctor that you see most of the time?

- ☐ 1. Yes ☐ 2. No

6. How many visits have you made to a doctor/nurse/clinic during the past 12 months?

- ☐ 1. No visits ☐ 2. 1 or 2 visits ☐ 3. 3 to 5 visits ☐ 4. 6 or more visits

7. How many miles is it one-way from your home to the doctor/nurse/clinic that you go to most often?

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8. Have you felt that your doctor/nurse/clinic refused to give you an appointment because you are on Medicaid?

- ☐ 1. Yes ☐ 2. No ☐ 3. Have not made an appointment

9. When you have made appointments with a doctor/nurse/clinic, about how long did it take to get in?

- ☐ 1. Within 1 day ☐ 3. Within 2 weeks ☐ 5. Have not made an appointment
☐ 2. Within 1 week ☐ 4. More than 2 weeks

10. How many visits have you made to a doctor/nurse/clinic for preventive reasons during the past 12 months (getting a shot/immunization, obtaining a yearly physical, those times when you weren't sick)?

- ☐ 1. No visits ☐ 2. 1 or 2 visits ☐ 3. 3 to 5 visits ☐ 4. 6 or more visits

11. How often have you been to a hospital emergency room during the past 12 months?

- ☐ 1. Never ☐ 2. Once ☐ 3. Twice ☐ 4. 3 times ☐ 5. 4 to 5 times ☐ 6. 6 or more times

11.(a). If you have gone to the emergency room, please mark ALL the reasons why you went:

- ☐ 1. Non-pregnancy related serious injury or illness that needed immediate attention.
☐ 2. Tried but could not get an appointment with my Primary Care Physician.
☐ 3. Easiest place to get medical care.
☐ 4. After regular clinic hours/regular clinic was closed.
☐ 5. Went into labor or some other pregnancy-related emergency.

12. How much of a problem, if any, was it to get a referral from your physician to see either an in-state or out-of-state specialist that you felt you needed? (Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care.)

- ☐ 1. Did not see a specialist ☐ 2. Not a problem ☐ 3. A small problem ☐ 4. A big problem

13. Have you received any services, including prescriptions, from a pharmacy during the past 12 months?

- ☐ 1. Yes ☐ 2. No

14. Do you request specific drugs when you see a physician?

- ☐ 1. Yes ☐ 2. No

15. Have you ever requested specific prescriptions from your physician based on advertisements that you have seen on television, heard on radio, or read in newspapers or magazines?

- ☐ 1. Yes ☐ 2. No

16. In your opinion, which types of drugs are MORE effective - generic or brand-name drugs?

- ☐ 1. Generic Drugs ☐ 2. Brand-name Drugs ☐ 3. Generic and brand-name drugs are equally effective

17. Have there been times that you have not been able to get medical care when needed during the past 12 months?

- ☐ 1. Yes ☐ 2. No - Skip to Question 19

18. If you answered "Yes" to Question 17, please mark ALL of the reasons why you have not been able to get medical care when you have needed it.

- ☐ 1. No transportation
☐ 2. No child care
☐ 3. Long waiting list for an appointment
☐ 4. Can't get an appointment
☐ 5. Had to wait too long at the clinic/doctor's office
☐ 6. Can't get time off from work
☐ 7. Don't know where to go
☐ 8. Doctor/clinic was not taking new patients
☐ 9. Doctor/clinic was not taking new Medicaid patients
☐ 10. Don't like doctors and hospitals
☐ 11. Uncomfortable telling doctor's office that Medicaid will pay for my medical care
☐ 12. People in the clinic/doctor's office were not nice to me
☐ 13. Lack of handicap accessibility
☐ 14. Language barriers (have a hard time understanding English)
☐ 15. Scared of doctors and hospitals
☐ 16. Can't pay the Medicaid co-payment/deductibles/recipient liability on physician office visits
☐ 17. Don't know what Medicaid does or does not cover

19. How often have you been to a dentist during the past 12 months?

- ☐ 1. Never ☐ 2. Once ☐ 3. Twice ☐ 4. 3 or more times

20. How many miles is it one-way from your home to the dentist that you go to most often?

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21. Have you, for any reason, ever missed a dental appointment?

- ☐ 1. No ☐ 2. Yes - How many?

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☐ 3. Have not made any dental appointments

22. Have you had any trouble getting needed dental care?

- ☐ 1. Have not needed any dental care. ☐ 2. No ☐ 3. Yes -

Have you had any trouble finding a dentist who takes patients on Medicaid? ☐ 1. Yes ☐ 2. No

23. Have you received any mental health or substance abuse services during the past 12 months?

- ☐ 1. No ☐ 2. Yes - Have you had any trouble getting mental health or substance abuse services you needed? ☐ 1. Yes ☐ 2. No

24. Have you used non-emergency medical-related transportation service during the past 12 months (i.e., you need to get to a medical appointment that is NOT an emergency, but you do not own a car or cannot get a ride from someone)?

- ☐ 1. Was not aware of service ☐ 2. No ☐ 3. Yes - How many times?

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Please rate your level of satisfaction for each of the statements below. Mark 5,4,3,2,1 where "5" stands for "VERY SATISFIED" and "1" stands for "VERY DISSATISFIED". If the statement does not apply to you, please mark "NA" for "Does Not Apply for Me".

	Very Satisfied					Very Dissatisfied				
25. The time spent at the office/clinic waiting to see your doctor or nurse.	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> NA				
26. How easy it is to get a referral to another doctor when <u>YOU</u> think you need it.	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> NA				
27. How easy it is to get the prescriptions you need.	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> NA				
28. How well your doctor or nurse explains things to you (like symptoms you have or any tests completed).	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> NA				
29. Advice your doctor or nurse gives/gave to you on how to take care of yourself and keep healthy.	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> NA				
30. Your doctor's, nurses's, or clinic's attitude toward people who are enrolled in Medicaid.	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> NA				
31. How satisfied you have been, overall, with your <u>doctor, nurse, or clinic</u> .	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> NA				
32. How satisfied have you been, overall, with any <u>specialists</u> you may have seen including your doctor if he or she is a specialist.	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> NA				
33. How satisfied have you been, overall, with any <u>dental care</u> you may have received.	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> NA				
34. How satisfied have you been, overall, with any <u>pharmacy services</u> you may have received.	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> NA				
35. How satisfied you have been, overall, with the <u>Medicaid Program</u> .	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> NA				

36. In your opinion, what are the **BEST** things about the Medicaid Program?

37. In your opinion, what are the **WORST** things about the Medicaid Program?

38. Do you have any children under the age of 21 (less than one year old through 20 years old) living AT HOME with you?

- ☐ 1. Yes- List ages of all of the children who live AT HOME with you
- ☐ 2. No - Please go to Question 49

39. Do any of your children have any of the following:

- A. Chronic illness or health conditions (for example: asthma or diabetes) ☐ 1. Yes ☐ 2. No
- B. Developmental or physical disability (for example: cerebral palsy or Down syndrome) ☐ 1. Yes ☐ 2. No
- C. Emotional or behavioral condition (for example: depression, or attention deficit hyperactivity disorder (ADHD)) ☐ 1. Yes ☐ 2. No

40. Have any of your children received care from a **DENTIST** during the past 12 months?

- ☐ 1. Yes ☐ 2. No - Why hasn't/haven't your child(ren) received any dental care? (Mark all that apply).
- ☐ 1. No teeth yet
- ☐ 2. Can't find dentist that will accept Medicaid patients
- ☐ 3. Can't afford dental care
- ☐ 4. Have not made an appointment yet
- ☐ 5. No problems
- ☐ 6. Other

41. Have any of your children attended a Well-Child Visit during the past 12 months (a visit where your child is seen when not sick)? ☐ 1. Yes ☐ 2. No

42. Have you ever heard of NORTH DAKOTA HEALTH TRACKS? ☐ 1. Yes ☐ 2. No- Please go to Question 49

43. Have you participated in North Dakota health Tracks during the past 12 months? ☐ 1. Yes ☐ 2. No- Please go to Question 49

44. Do you feel it is easy to get a Health Tracks appointment? ☐ 1. Yes ☐ 2. No

45. When your child(ren) was/were screened by Health Tracks staff, were any referrals made for follow-up care?

- ☐ Yes - Who made the referral(s)? ☐ 1. Public Health ☐ 2. Doctor
- ☐ 2. No

46. If a referral was made for follow-up services, did your child(ren) keep the appointment(s)? ☐ 1. Yes ☐ 2. No

47. How useful have Health Track services been in your child(ren)'s health?

- ☐ 1. Very useful ☐ 2. Somewhat useful ☐ 3. Not very useful ☐ 4. Not useful at all

48. List any suggestions about how the Health Tracks Program may be improved.

49. Please rank each of the twelve services listed below in order of importance to you from 1 to 12, with "1" being the MOST IMPORTANT and "12" being the LEAST IMPORTANT. (Use each number only ONCE...no ties.)

<input type="text"/>	<input type="text"/>	Chiropractic
<input type="text"/>	<input type="text"/>	Dental
<input type="text"/>	<input type="text"/>	Drugs
<input type="text"/>	<input type="text"/>	Durable Medical Equipment (such as wheelchair)
<input type="text"/>	<input type="text"/>	Hospice (care for the dying)
<input type="text"/>	<input type="text"/>	Occupational Therapy

<input type="text"/>	<input type="text"/>	Optometry (routine eye care)
<input type="text"/>	<input type="text"/>	Physical Therapy
<input type="text"/>	<input type="text"/>	Private Duty Nursing
<input type="text"/>	<input type="text"/>	Prosthetics and Orthotics (such as leg brace)
<input type="text"/>	<input type="text"/>	Psychological Services
<input type="text"/>	<input type="text"/>	Speech and Hearing Services

BACKGROUND INFORMATION ABOUT YOU

50. Which of the following best describes your education?

- ☐ 1. 8th grade or less
☐ 2. Some high school
☐ 3. High school graduate or GED
☐ 4. Some college or 2-year degree
☐ 5. 4-year college graduate
☐ 6. More than 4-year college graduate

51. Are you currently employed part-time (less than 40 hours per week), full-time (40 or more hours per week), not currently employed, or retired?

- ☐ 1. Part-time (less than 40 hours per week)
☐ 2. Full-time (40 or more hours per week)
☐ 3. Not currently employed
☐ 4. Retired

52. Which of the following describes you best?

- ☐ 1. Single ☐ 2. Married ☐ 3. Separated ☐ 4. Divorced ☐ 5. Widowed

53. Gender

- ☐ 1. Male ☐ 2. Female

54. What is your age now?

- ☐ 1. Under 18 ☐ 5. 45-54
☐ 2. 18-24 ☐ 6. 55-64
☐ 3. 25-34 ☐ 7. 65-74
☐ 4. 35-44 ☐ 8. 75 or older

55. Which of the following best describes you?

- ☐ 1. American Indian or Alaskan Native
☐ 2. Asian or Pacific Islander
☐ 3. Black (not of Hispanic origin)
☐ 4. Hispanic
☐ 5. White (not of Hispanic origin)
☐ 6. Two or more races

56. What is your five-digit zip code?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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57. Is English the MAIN language spoken in your home?

- ☐ 1. Yes ☐ 2. No - What language do you MAINLY speak at home?

<input type="text"/>
